TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FIRST CHOICE SURGERY CENTER

Respondent Name
TRAVELERS INDEMNITY CO OF CONNECTICUT

MFDR Tracking Number
M4-16-3283-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
June 27, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please accept form DWC060 as First Choice Surgery Center of Baton Rouge, Medical Fee Dispute Resolution Request. I have attached copies of all correspondence with Travelers Indemnity Workers' Compensation Company in chronological order for your review:

1. Email dated 05/20/2016 with attachment
2. Travelers' response generated 05/26/2016 to above mentioned email
3. Second level appeal letter dated 06/02/2016 with accompanying documentation to support my request for additional payment."

Amount in Dispute: $27,373.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider alleges they are entitled to reimbursement for the services at issue. The Carrier has reviewed the Medicare base rate and calculations utilized and determined that the Maximum Allowable Reimbursement was properly calculated, as the Provider failed to supply the invoice for the implantable devices for which they were seeking reimbursement. The Carrier contends the Provider is not entitled to additional reimbursement for the disputed services.

Furthermore, this Request for Medical Fee Dispute Resolution should be dismissed as not timely filed under Rule 133.307(c)(1). The rule requires the Request be filed no later than one year from the date of service. As the date of service in dispute is 01-23-2012, the Request was required to be filed no later than 01-23-2013. As evidenced by the Division's date stamp, the Request for Medical Fee Dispute Resolution was filed on 06-27-2016, or over 3 years late."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 2012	CPT Codes E0783, 62362 and 62350	$27,373.77	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information which is needed for adjudication
   - DOCI – Invoice requested for payment. Please fax copy of EORBILL with invoice to Sergio @ 888-558-8656
   - P18A W3 – Additional payment made on appeal/reconsideration. Based on additional information received and approval from adjuster, and adjustment is being made to the total reimbursement of the original invoice
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
   - 1115 – We find the original review to be accurate and are unable to recommend any additional allowance
   - Z036 – Appeals will not be considered after the first day of the 11th month

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute is January 23, 2012. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on June 27, 2016. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		8/5/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.